HSTA-R
EC-2H
DEC 2010

Hawai'i Employer-Union Health Benefits Trust Fund

HSTA: Enrollment Form For HSTA Retirees

PLEASE SUBMIT THIS FORM EC-2H TO THE EUTF

The EUTF created new health and life insurance benefit plans for HSTA VEBA retirees in response to the December 7, 2010 oral ruling by Judge Sakamoto. The new plans offer HSTA VEBA members the same standard of coverage in benefits that they enjoyed under their HSTA VEBA plans. All HSTA VEBA retirees will be transitioned to the newly created EUTF plans that offer the same standard of coverage in benefits on January 1, 2011.

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retiree and dependent enrollments

Name (Last, First, Middle)

_____

Home Phone (_____) _____

Mobile Phone (_____) _____

Residence Address (☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

Mailing Address (if different from above)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

☐ Open Enrollment

Retiree's Social Security Number (SSN) or EUTF ID Number

_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____/_____/_____

If you are including your spouse or domestic partner in your health benefit plans, please complete Section 4

☐ Mid- Year Qualifying Event:

_____

Event Date: _____/_____/_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

Domestic Partnership (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)

_____/_____/_____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her
SSN:_____ or
EUTF ID:_____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

Skip this section if Retiree does NOT pay towards health plan benefits

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Contribution Start Dates. If your event is listed below and *you pay towards your health benefits plan*, please select one of the three options; otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Marriage, New Domestic Partnership, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section

☐ Coverage starts day of the event & premium contributions start first day of the pay period* in which the effective date of coverage occurs (if no selection is made, this option will be used)

☐ Coverage & premium contributions start first day of the first pay period* following event

☐ Coverage & premium contributions start first day of the second pay period* following event

*(1st or 16th of month)

SECTION 3: PLAN SELECTION

Make your selection by checking the box for the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection.

Medical Plan

Choose only one box in each plan section

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
	HMSA 90/10 PPO Medical and Drug, VSP Vision & Chiro Plan Program	☐	☐	☐	☐
	Hawaii Kaiser Foundation Medical and Drug, VSP Vision & Chiro Plan Program	☐	☐	☐	☐

Other Plans

		Cancel/Waive	Self	2-Party	Family
	Hawai'i Dental Service **(HDS)** Dental Plan	☐	☐	☐	☐
Life	Standard Insurance Company	☐	☐		

SSN or EUTF ID# _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent(s): Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number or EUTFID Number	*Relationship	Gender M/F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawai'i Revised Statutes.
Dependent Certification and Student Certification– See Sections 4.6 and 4.7 of "Instructions for Completing Form EC-2"for more information.

I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ (initials)

Domestic Partner Certification – See Sections 4.8 and 4.9 of "Instructions for Completing Form EC-2" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: MEDICARE

Chapter 87A-23(4) requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee:

Medicare Claim #: (ID number listed on the blue and red Medicare Card)

Non-EUTF Medicare Part D

If you or your dependent(S) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

Name(s):

SECTION 6: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage Self	2-Party	Family
			/ /	☐	☐	☐
			/ /	☐	☐	☐

SECTION 7: RETIREE SIGNATURE

NOTE: The enrollment of HSTA VEBA members into these new health and other benefit plans is being done solely to comply with Judge Sakamoto's oral ruling and not to create any constitutional or contractual right to the benefits provided by these plans. Please note that the State does not agree with Judge Sakamoto's ruling and reserves the right to move HSTA VEBA members into regular EUTF plans if Judge Sakamoto's ruling is overturned or modified.

I am eligible for the coverage requested and declare that the individuals listed on the enrollment form are also eligible. I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Retiree Signature: _____ Date Signed: _____

Please submit your signed and completed form via mail to:

EUTF
P.O. Box 2121
Honolulu HI 96805-2121

Customer Service:

Oahu (808) 586-7390
Toll Free 1 (800) 295-0089

Or hand deliver at: EUTF, 201 Merchant St., Suite 1520, Honolulu HI 96813